

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0027045</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>St Joseph's Home For The Elderly</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>80 West Northwest Highway</u> <u>Palatine</u> <u>60067</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>Mother Benedict Armstrong</u> (Title) <u>President</u>	
<b>Telephone Number:</b> <u>( 847 ) 358-5700</u> <b>Fax #</b> <u>( 847 ) 358-5719</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Elizabeth Vaccariello</u> <u>Vice President</u> (Firm Name & Address) <u>Varey &amp; Vaccariello CPAs PC</u> <u>617E Golf Road, Suite 107, Arlington Heights, IL 60005</u> (Telephone) <u>( 847 ) 228-6977</u> <b>Fax #</b> <u>( 847 ) 228-0317</u>	
<b>IDPA ID Number:</b> <u>36-2443793 / 001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>01/09/1967</u>			
<b>Type of Ownership:</b>			
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
<b>IRS Exemption Code</b> <u>501c3</u>			
<input type="checkbox"/> <b>PROPRIETARY</b>			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>GOVERNMENTAL</b>			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Mother Benedict Armstrong</u> <b>Telephone Number:</b> <u>( 847 ) 358-5700</u>			



## STATE OF ILLINOIS

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Facility Name & ID Number St Joseph's Home For The Elderly# 0027045 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsNo Change

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>20</u>	Skilled (SNF)	<u>20</u>	<u>7,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>31</u>	Intermediate (ICF)	<u>31</u>	<u>11,315</u>	3
4		Intermediate/DD			4
5	<u>16</u>	Sheltered Care (SC)	<u>16</u>	<u>5,840</u>	5
6		ICF/DD 16 or Less			6
7	<u>67</u>	TOTALS	<u>67</u>	<u>24,455</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>14,784</u>	<u>2,489</u>		<u>17,273</u>	10
11	ICF/DD					11
12	SC	<u>1,377</u>	<u>3,363</u>		<u>4,740</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,161</u>	<u>5,852</u>		<u>22,013</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 90.01%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 01/09/1967

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

\* All facilities other than governmental must report on the accrual basis.



## STATE OF ILLINOIS

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Facility Name &amp; ID Number

St Joseph's Home For The Elderly

# 0027045

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	286,252	4,134	68,421	358,807		358,807	(52,279)	306,528		1
2	Food Purchase		78,731		78,731		78,731		78,731		2
3	Housekeeping		10,546	244,640	255,186		255,186		255,186		3
4	Laundry	62,117	9,918	34,822	106,857		106,857	(8,053)	98,804		4
5	Heat and Other Utilities			238,794	238,794		238,794	(93,227)	145,567		5
6	Maintenance	165,200	26,621	164,305	356,126		356,126	(103,444)	252,682		6
7	Other (specify):*	66,231		4,703	70,934		70,934		70,934		7
8	<b>TOTAL General Services</b>	579,800	129,950	755,685	1,465,435		1,465,435	(257,003)	1,208,432		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,337,419	37,261	214,622	1,589,302		1,589,302		1,589,302		10
10a	Therapy	63,654		1,038	64,692		64,692		64,692		10a
11	Activities	66,229	9,381	4,045	79,655		79,655		79,655		11
12	Social Services	18,669		838	19,507		19,507		19,507		12
13	Nurse Aide Training										13
14	Program Transportation			4,482	4,482		4,482		4,482		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,485,971	46,642	227,425	1,760,038		1,760,038		1,760,038		16
	<b>C. General Administration</b>										
17	Administrative			18,000	18,000		18,000		18,000		17
18	Directors Fees										18
19	Professional Services			47,343	47,343		47,343		47,343		19
20	Dues, Fees, Subscriptions & Promotions			55,548	55,548		55,548	(40,640)	14,908		20
21	Clerical & General Office Expenses	212,407	13,418	182,093	407,918		407,918		407,918		21
22	Employee Benefits & Payroll Taxes			449,250	449,250		449,250		449,250		22
23	Inservice Training & Education			4,226	4,226		4,226		4,226		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			13,445	13,445		13,445		13,445		25
26	Insurance-Prop.Liab.Malpractice			43,144	43,144		43,144	(6,942)	36,202		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	212,407	13,418	813,049	1,038,874		1,038,874	(47,582)	991,292		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,278,178	190,010	1,796,159	4,264,347		4,264,347	(304,585)	3,959,762		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.



## STATE OF ILLINOIS

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Facility Name &amp; ID Number

St Joseph's Home For The Elderly

#0027045

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			482,828	482,828		482,828	(56,711)	426,117			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			482,828	482,828		482,828	(56,711)	426,117			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			27,923	27,923		27,923		27,923			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			27,923	27,923		27,923		27,923			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,278,178	190,010	2,306,910	4,775,098		4,775,098	(361,296)	4,413,802			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.



Facility Name & ID Number St Joseph's Home For The Elderly# 0027045

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(52,279)	1		4
5 Telephone, TV & Radio in Resident Rooms	(4,425)	5		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients	(8,053)	4		8
9 Non-Straightline Depreciation	(56,711)	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions	(88,802)	5		15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	303	6		17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance	(6,942)	26		21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(40,640)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Page 5A & Page 5B	(103,747)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (361,296)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (361,296)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47



St Joseph's Home For The ElderlyID# 0027045Report Period Beginning: 01/01/2003Ending: 12/31/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Line 15 - Non-Care Related Owner's Transactions	\$ (103,747)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(103,747)		49



## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number St Joseph's Home For The Elderly

# 0027045

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(52,279)	0	0	0	0	0	0	0	0	0	0	(52,279)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(8,053)	0	0	0	0	0	0	0	0	0	0	(8,053)	4
5	Heat and Other Utilities	(93,227)	0	0	0	0	0	0	0	0	0	0	(93,227)	5
6	Maintenance	(103,444)	0	0	0	0	0	0	0	0	0	0	(103,444)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(257,003)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(257,003)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(40,640)	0	0	0	0	0	0	0	0	0	0	(40,640)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(6,942)	0	0	0	0	0	0	0	0	0	0	(6,942)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(47,582)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(47,582)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(304,585)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(304,585)</b>	<b>29</b>







Facility Name & ID Number St Joseph's Home For The Elderly# 0027045

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Little Sisters of the Poor - Chicago		
				Province, Inc.	Palatine, IL	Religious Order
				Little Sisters of the Poor -		
				St. Mary's Home	Chicago, IL	Nursing Home

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ -0-			\$ -0-	\$ * -0-	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.



## STATE OF ILLINOIS

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Facility Name & ID Number St Joseph's Home For The Elderly # 0027045 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ -0-		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION



Facility Name & ID Number St Joseph's Home For The Elderly # 0027045 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization N/A  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( )  
 Fax Number ( )

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ -0-	\$ -0-		\$ -0-	25



**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Little Sisters of the Poor						\$		\$			\$	1
2	- Chicago Province, Inc.	X		Construction	NONE	Various	4,363,320	4,363,320	Various	0.0300	-0-		2
3													3
4													4
5													5
	Working Capital												
6	Little Sisters of the Poor												6
7	- Chicago Province, Inc.	X		Working Capital	NONE	Various	1,258,650	1,258,650	Various	0.0300	-0-		7
8													8
9	TOTAL Facility Related						\$	5,621,970	\$	5,621,970			9
	B. Non-Facility Related*												
10	Little Sisters of the Poor												10
11	- Chicago Province, Inc.	X		Convent Allocation	NONE	Various	1,078,030	1,078,030	Various	0.0300	-0-		11
12													12
13													13
14	TOTAL Non-Facility Related						\$	1,078,030	\$	1,078,030			14
15	TOTALS (line 9+line14)						\$	6,700,000	\$	6,700,000			15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ -0- Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)



Facility Name & ID Number **St Joseph's Home For The Elderly**# **0027045** Report Period Beginning: **01/01/2003** Ending: **12/31/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$	-0-	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	-0-	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	-0-	3	
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	-0-	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	-0-	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$      For      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	-0-	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	-0-	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1998	-0-	8		
	1999	-0-	9		
	2000	-0-	10		
	2001	-0-	11		
	2002	-0-	12		
				<b>FOR OHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    St Joseph's Home For The Elderly    COUNTY    Cook

FACILITY IDPH LICENSE NUMBER    0027045

CONTACT PERSON REGARDING THIS REPORT    Mother Benedict Armstrong

TELEPHONE    ( 847 ) 358-5700    FAX #:    ( 847 ) 358-5719

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		<b>TOTALS</b>	\$ <u></u>	\$ <u></u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?     YES     NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.



A. Square Feet:

119,979

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

3

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

32 APTS. INDEPENDENT LIVING FACILITIES - NOT a separate entity. Facility is NOT run as a business, but is a part of the mission of the Little Sisters of the Poor - taking care of the elderly poor. See page 23A for additional information. Expenses for the apartments are NOT included in this cost report.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Existing Structure	653,400	1966	\$ 76,284	1
2					2
3	TOTALS	653,400		\$ 76,284	3



Facility Name &amp; ID Number St Joseph's Home For The Elderly

# 0027045

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	67	1966	1966	\$ 3,221,573	\$ 95,983	40	\$ 80,539	\$ (15,444)	\$ 2,965,316
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Health Related Renovation	1967		24,177	721	40	604	(117)	21,836
10	Health Related Renovation	1968		34,542	1,029	40	863	(166)	30,486
11	Health Related Renovation	1969		26,308	784	40	658	(126)	22,677
12	Health Related Renovation	1970		40,716	1,213	40	1,018	(195)	34,255
13	Health Related Renovation	1971		22,307	665	40	558	(107)	18,079
14	Health Related Renovation	1972		119,419	3,558	40	2,986	(572)	95,526
15	Health Related Renovation	1974		10,272	306	40	257	(49)	7,789
16	Health Related Renovation	1975		9,671	288	40	242	(46)	7,139
17	Health Related Renovation	1976		965	29	40	24	(5)	691
18	Health Related Renovation	1978		44,279	1,319	40	1,107	(212)	29,460
19	Interior Renovation - Conversion from Wards to Rooms	1983		3,663,633	109,154	40	91,591	(17,563)	1,944,097
20	New Fire Door System	1984		25,217	751	40	630	(121)	12,536
21	Complete Boiler Renovation	1985		470,291	14,012	40	11,757	(2,255)	221,661
22	Electrical Repairs & New Cooling System for Boilers	1987		106,618	3,177	40	2,666	(511)	44,731
23	Concrete Restoration	1990		111,172	3,312	40	2,779	(533)	38,083
24	Exterior Renovation Including New Windows	1991		317,750	9,467	40	7,944	(1,523)	100,560
25	Driveway Restored	1991		32,334		10			32,334
26	Sewer Renovation	1992		13,999	417	40	350	(67)	4,058
27	Asbestos Removal & Central Air Conditioning	1992		1,051,235	31,320	40	26,281	(5,039)	314,249
28	Remodel Center & West Wings	1993		2,619,173	78,035	40	65,479	(12,556)	681,954
29	Pond Dredge	1995		24,711	2,104	14	1,765	(339)	15,003
30	Back Driveway Replaced	1996		57,358	6,836	10	5,736	(1,100)	43,020
31	Patio and Sidewalk Restoration	1998		27,055	3,225	10	2,706	(519)	14,883
32	Asphalt Paving	1998		1,888	224	10	189	(35)	1,035
33	Front Walkway Lighting Restoration	1998		2,892	344	10	289	(55)	1,589
34	Brick Paving, Concrete and Electric for Front Walkway/Sitting Area	2000		11,634	1,386	10	1,163	(223)	4,071
35	Evergreens, Statue and Pedestal	2003		6,168	184	20	154	(30)	154
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	1998 CBR - B-Room Floor, Patio Flash, Door & Fire Alarm Panel	1998	\$ 8,558	\$	5	\$ 854	\$ 854	\$ 8,558	37
38	1999 Cap Building Repairs - Mechanical Valve Repair	1999	2,349		5	470	470	2,115	38
39	2000 Cap Bldg Repairs - Repair to Trans Equip & Fire System	2000	4,026		5	805	805	2,818	39
40	2001 Cap Bldg Repairs - Windows, Flooring & Asbestos	2001	35,129		5	7,026	7,026	17,565	40
41	2002 Cap Bldg Repairs - Autos, Flooring, Generator & Asphalt	2002	20,551		5	4,110	4,110	6,165	41
42	2003 Cap Bldg Repairs - Caulking, Flooring, Water Main Repair	2003	87,055		5	8,706	8,706	8,706	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 12,255,025	\$ 369,843		\$ 332,306	\$ (37,537)	\$ 6,753,199	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	1974 IH Cub Tractor	1974	\$ 1,510	\$	\$	\$	5	\$ 1,510	76
77	Care Use	1989 M/F Diesel Tractor	1989	21,817				4	21,817	77
78	Care Use	1987 Ford Mini Bus	1986	36,054				4	36,054	78
79	Care Use	1987 Ford Truck	1987	12,793				4	12,793	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.



C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	1994 Lewis Riding Mower	1994	\$ 5,807	\$	\$	\$	4	\$ 5,807	76
77	Care Use	1996 Chev Lumina Van	1996	15,118				4	15,118	77
78	Care Use	1997 Chevy Astro Van	1997	14,852				4	14,852	78
79	Care Use	1998 Steer-Rite Pallet Tr	1998	470				4	470	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.



C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	1999 GreatChariot Mower	1999	\$ 6,521	\$ 971	\$ 816	\$ (155)	4	\$ 6,521	76
77	Care Use	1999 Ford Taurus Wagon	1999	14,409	2,147	1,802	(345)	4	14,409	77
78	Care Use	2000 Dodge Ram Van	1999	19,703	4,122	2,462	(1,660)	4	19,703	78
79	Care Use	1995 Nissan Pathfinder	2000	2,098	625	525	(100)	4	1,837	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.



C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 737,816	\$ 99,281	\$ 83,307	\$ (15,974)	10 Years	\$ 333,965	71
72	Current Year Purchases	40,049	2,386	2,002	(384)	10 Years	2,002	72
73	Fully Depreciated Assets	446,911				10 Years	446,911	73
74								74
75	TOTALS	\$ 1,224,776	\$ 101,667	\$ 85,309	\$ (16,358)		\$ 782,878	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	1992 Plymouth Acclaim	2001	\$ 3,239	\$ 965	\$ 810	\$ (155)	4	\$ 2,025	76
77	Care Use	1996 Pontiac Grand Prix	2002	6,168	1,838	1,542	(296)	4	2,313	77
78	Care Use	1996 Mercury Villager Van	2003	4,363	650	545	(105)	4	545	78
79										79
80	TOTALS			\$ 164,922	\$ 11,318	\$ 8,502	\$ (2,816)		\$ 155,774	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 13,721,007	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 482,828	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 426,117	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (56,711)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,691,851	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Bldg - Convent Allocation Various	\$ 2,319,705	\$ 59,508	\$ 1,103,798	86
87	Equip - Convent Allocation Various	234,854	16,358	150,119	87
88	Vehicles - Convent Allocation Var	31,625	2,816	29,869	88
89					89
90					90
91	TOTALS	\$ 2,586,184	\$ 78,682	\$ 1,283,786	91

G. Construction-in-Progress

	Description	Cost	
92	Updating of Bldg Mech Sys	\$ 160,330	92
93			93
94			94
95		\$ 160,330	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.



**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ \_\_\_\_\_

13. /2005 \$ \_\_\_\_\_

14. /2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.



**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**\* ALL AIDES EMPLOYED HAVE PREVIOUSLY OBTAINED THE NECESSARY TRAINING**

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.



**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language Development Therapist		hrs								2
2	Licensed Recreational Therapist		hrs								3
3	Licensed Physical Therapist		hrs								4
4	Physician Care		visits								5
5	Dental Care		visits								6
6	Work Related Program		hrs								7
7	Habilitation		hrs								8
8			# of prescrpts								9
9	Pharmacy										
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
10	Academic Education		hrs								11
11	Exceptional Care Program										12
12											
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.



## STATE OF ILLINOIS

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Facility Name &amp; ID Number St Joseph's Home For The Elderly

# 0027045

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 492,952	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000 )	208,933		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,345		6
7	Other Prepaid Expenses	132		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Donations Receivable	157,538		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 890,900	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,387		13
14	Buildings, at Historical Cost	14,417,062		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,656,177		16
17	Accumulated Depreciation (book methods)	(8,929,708)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	160,330		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 7,415,248	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 8,306,148	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 42,540	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,425		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 92,965	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	6,700,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 6,700,000	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 6,792,965	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,513,183	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 8,306,148	\$	48

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,481,836</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,481,836</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(968,653)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(968,653)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,513,183</b>	<b>24 *</b>

\* This must agree with page 17, line 47.



**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,135,261	1
2	Discounts and Allowances for all Levels	(449,658)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,685,603	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	2,119,902	24
25	Interest and Other Investment Income***	940	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,120,842	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,806,445	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,465,435	31
32	Health Care	1,760,038	32
33	General Administration	1,038,874	33
	<b>B. Capital Expense</b>		
34	Ownership	482,828	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	27,923	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,775,098	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(968,653)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (968,653)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number St Joseph's Home For The Elderly# 0027045Report Period Beginning: 01/01/2003Ending: 12/31/2003

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing	1,998	2,306	62,718	27.20	2
3	Registered Nurses	18,469	20,583	445,276	21.63	3
4	Licensed Practical Nurses	6,362	6,592	118,922	18.04	4
5	Nurse Aides & Orderlies	42,980	47,563	673,202	14.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,352	3,949	63,654	16.12	8
9	Activity Director	1,779	1,906	31,318	16.43	9
10	Activity Assistants	3,201	3,382	34,911	10.32	10
11	Social Service Workers	1,172	1,265	18,669	14.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,321	26,869	286,252	10.65	15
16	Dishwashers					16
17	Maintenance Workers	7,200	8,474	165,200	19.49	17
18	Housekeepers					18
19	Laundry	5,920	6,423	62,117	9.67	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,045	14,238	212,407	14.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,890	2,201	37,301	16.95	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security Guards</u>	4,338	4,700	66,231	14.09	33
34	TOTAL (lines 1 - 33)	136,027	150,451	\$ 2,278,178 *	\$ 15.14	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	112	\$ 3,920	1-3	35
36	Medical Director	96	2,400	9-3	36
37	Medical Records Consultant	18	990	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	22	917	10-3	39
40	Physical Therapy Consultant	21	1,038	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	1,800	11-3	44
45	Social Service Consultant	17	838	12-3	45
46	Other(specify) <u>Stipend for One</u>				46
47	<u>Sister Acting as Director of</u>				47
48	<u>Nursing at \$750 For 12 Months</u>	2,080	9,000	10-3	48
49	TOTAL (lines 35 - 48)	2,406	\$ 20,903		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	209	\$ 12,354	10-3	50
51	Licensed Practical Nurses	164	8,448	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	373	\$ 20,802		53



Facility Name & ID Number St Joseph's Home For The Elderly# 0027045Report Period Beginning: 01/01/2003Ending: 12/31/2003

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount	
Name	Function	%		Description				Description				
			\$	Workers' Compensation Insurance	\$	26,794		IDPH License Fee	\$			
				Unemployment Compensation Insurance		22,241		Advertising: Employee Recruitment			3,012	
				FICA Taxes		174,281		Health Care Worker Background Check				
				Employee Health Insurance		174,552		(Indicate # of checks performed <u>34</u> )			408	
				Employee Meals				Public Relations			40,640	
				Illinois Municipal Retirement Fund (IMRF)*				Subscriptions			2,588	
				Retirement Plan		49,262		Licenses and Fees			1,835	
				Employee Physicals		2,120		Dues - Life Services Network of IL			3,676	
								Dues - Buying Service			2,684	
								Dues - Misc			705	
								Less: Public Relations Expense			(40,640)	
								Non-allowable advertising	(		)	
								Yellow page advertising	(		)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$	TOTAL (agree to Schedule V, line 22, col.8)			\$	TOTAL (agree to Sch. V, line 20, col. 8)			\$
B. Administrative - Other												
Description				Amount								
Stipend for Two Sisters Acting as Administrator and				\$								
Assistant Administrator at \$750 For 12 Months Per Sister				18,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$								
				18,000								
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount		Description	Amount			
R. E. Harrington	Unemploy Comp Consult	\$ 286				\$		Out-of-State Travel	\$			
ADP	Payroll Processing	11,476										
Varey & Vaccariello CPAs PC	Accounting and Auditing	28,350										
Jackson Lewis	Legal (Care Related)	1,315						In-State Travel				
Little Sisters of the Poor	Corporate Compliance	5,916										
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$	TOTAL			\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)			\$
				47,343								

\* Attach copy of IMRF notifications

\*\*See instructions.



**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting	01/2001	\$ 3,474	3 Yrs	\$	\$ 1,158	\$ 1,158	\$ 1,158	\$	\$	\$	\$	\$
2	Plumbing Repairs	08/2001	2,655	3 Yrs		369	885	885	516				
3	Painting	11/2001	4,825	3 Yrs		268	1,608	1,608	1,341				
4	Plumbing Repairs	11/2001	2,836	3 Yrs		158	945	945	788				
5	Plumbing Repairs	12/2002	1,899	3 Yrs			53	633	633	580			
6	Plumbing Repairs	01/2003	2,339	3 Yrs				780	780	779			
7	Boiler Repair	12/2003	2,507	3 Yrs				70	836	836	765		
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 20,535		\$	\$ 1,953	\$ 4,649	\$ 6,079	\$ 4,894	\$ 2,195	\$ 765	\$	\$



Facility Name & ID Number St Joseph's Home For The Elderly

STATE OF ILLINOIS

# 0027045

Report Period Beginning: 01/01/2003

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES N/A NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 27,923  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ -0- Has any meal income been offset against related costs? No Indicate the amount. \$ -0-
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 25% for  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Varey & Vaccariello, CPAs PC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.